

Entergy Nuclear Generation Co. Pilgrim Nuclear Power Station 600 Rocky Hill Road Plymouth, MA 02360

Mike Bellamy Site Vice President

February 25, 2002

U.S. Nuclear Regulatory Commission Attention: Document Control Desk

Washington, D.C. 20555

SUBJECT:

Entergy Nuclear Generation Company

Pilgrim Nuclear Power Station

Docket No. 50-293 License No. DPR-35

Licensee Event Report 2001-007-00

LETTER NUMBER: 2.02.007

Dear Sir:

The enclosed Licensee Event Report (LER) 2001-007-00, "Automatic Scram During Transient Caused by Failure of Calibrating Unit." is submitted in accordance with 10 CFR 50.73.

This letter contains no commitments.

Please do not hesitate to contact me if there are any questions regarding this report.

Sincerely,

Mike Bellamy

DWE/jbb

Enclosure: LER 2001-007-00

CC:

Mr. Hubert J. Miller

Regional Administrator, Region 1 U.S. Nuclear Regulatory Commission

FOR DM'S

475 Allendale Road

King of Prussia, PA 19406

Mr. Douglas Starkey, Project Manager Office of Nuclear Reactor Regulation

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U. S. Nuclear Regulatory Commission

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INPO Records

NRC Form 366 (6-1998)

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

(See reverse for number of digits/characters for each block)

FACILITY NAME (1)

PILGRIM NUCLEAR POWER STATION

APPROVED BY OMB NO. 3150-0104

Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the Records Management Branch (T-6 F33), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503. If an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

DOCKET NUMBER (2)

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TITLE (4)

Automatic Scram During Transient Caused by Failure of Calibrating Unit

EVENT DATE (5)				LER NUMBER (6)		REP	ORT DA	ATE (7)		OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	F	ACILITY NAME N/A	DOCKET NUMBER 05000	
12	27	2001	2001	007	00	02	25	2002	F	ACILITY NAME N/A	DOCKET NUMBER 05000	
OPER/	ATING		THIS RE	PORT IS SUBMITTED	PURSUA	NT TO TH	E REQL	IREMENT	SO	F 10 CFR: (Check one	or more) (11)	
MOD	E (9)	N	20.2201 (b)			20.2203(a)(2)(v)				50.73(a)(2)(i)(B)	50.73(a)(2)(viii)	
POW	/ER		22.2203(a)(1) 053 20.2203(a)(2)(i)			20.2203(8	a)(3)(i)			50.73(a)(2)(ii)(B)	50.73(a)(2)(x)	
LEVEL	(10)	053					20.2203(a)(3)(ii)			50.73(a)(2)(iii)	73.71	
			20.22	203(a)(2)(ii)		20.2203(8	1)(4)		X	50.73(a)(2)(iv)(A)	OTHER	
		7	20.22	203(a)(2)(iii)		50.36(c)(1)			50.73(a)(2)(v)(D)	Specify in Abstract below	
			20.22	203(a)(2)(iv)		50.36(3)(1)(ii)(A)			50.73(a)(2)(vii)(D)	or in NRC Form 366A	
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LICENSEE CONTACT FOR THIS LER (12)

NAME
Bryan S. Ford – Licensing Manager

TELEPHONE NUMBER (Include Area Code)

(508) 830-8403

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX		CAUSE	SYSTEM	COMPONENT	MANUFACTI	JRER	REPORT TO E	
X	JG	TD	R369	Υ								
		SUPI	PLEMENTAL REPO	ORT EXPECTED	2 (14	4)			XPECTED	MONTH	DAY	YEAR
YES (If ye		XPECTED SUBMI	SSION DATE)	X	1	NO			JBMISSION DATE(15)			

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On December 27, 2001 at 1321 hours, an automatic Reactor Protection System scram signal and scram occurred during a surveillance test performed while at 100 percent reactor power. The scram resulted in the automatic insertion of all control rods.

The direct cause of the scram was an automatic trip of both Recirculation System motor-generator sets that caused decreased core flow resulting in a trip signal from the neutron monitoring system flow control trip reference circuits. The root cause of the scram was an internal failure, during the required surveillance test, of an analog trip system calibrating unit that was not reproducible. Circuit analysis identified the most likely failed component within the unit was an intermittent micro-switch. A failed micro-switch would apply a voltage from the calibrating unit to a selected master trip unit while rotating the same rotary selector switch between channels. Corrective action taken included replacement of the suspect calibrating unit.

The event posed no threat to public heath and safety.

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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

BACKGROUND

The analog trip system consists of transmitters, master and slave trip units, power supplies, and calibrating units. The transmitters are located on instrument racks connected to the reactor vessel or drywell, and function to monitor parameters that include reactor vessel water level and pressure and Drywell pressure. The trip units are installed in instrument panels and receive signals from the transmitters. The trip units function to initiate signals to the related systems. The calibrating units are used for calibration of the trip units.

The anticipated transient without scram (ATWS) panels are part of the instrument channels for the alternate rod insertion function (ARI), feedwater pump trip function, and recirculation pump trip (RPT) function. The RPT functions to trip the circuit breakers of the motors that drive the reactor recirculation motor-generator (MG) sets. Each MG set provides power to the respective reactor recirculation pump. The recirculation pumps provide the motive force for reactor core flow. There are two ATWS divisions, Division 1 and Division 2. Each division is designed to fulfill the ATWS trip functions and is housed in a separate panel.

Technical Specifications 3.2.G and 4.2.G pertain to the operability and surveillance requirements for the ATWS ARI and RPT trip functions. The required surveillance test includes testing of the panel power supplies, calibration of the trip units, and functional tests of trip relays and indicating lights. The surveillance is performed in accordance with approved procedure.

On December 27, 2001, plant conditions included the following: The reactor was operating at 100 percent power. The reactor mode selector switch was in the RUN position. The reactor vessel pressure was approximately 1034 psig with the reactor water at the saturation temperature for that pressure. The reactor vessel water level was +30" (narrow range) and was being controlled in the three element control mode. Reactor core flow was in the loop control mode. Reactor core flow was approximately 55.5 E+06 pounds per hour. The ATWS Division 2 components were being surveillance tested in accordance with PNPS Procedure 8.M.1-29 (Rev. 34) Attachment 2.

After the satisfactory test of the Division 2 power supplies, calibrating unit preparation, calibrations of three master trip units and one slave trip unit, and functional tests of the related relays and indicating lights, master trip unit PIS-263-123D and the related relays and indicating lights were to be calibrated and functionally tested. After verifying the prerequisites and reviewing the precautions, the Division 2 calibrating unit "Press to Cal" knob (smaller knob) was pulled out and the larger knob was set to slot number 5 (PIS-263-123D) in accordance with the procedure. This action resulted in the unexpected trip of both reactor recirculation MG sets and consequent trip of the recirculation pumps.

EVENT DESCRIPTION

On December 27, 2001 at 1321 hours, an automatic Reactor Protection System (RPS) scram signal and scram occurred during a transient while at approximately 53 percent reactor power. The scram was uncomplicated and resulted in the automatic insertion of the control rods, automatic transfer of source of the plant's electrical power system, automatic trip of the main turbine generator, and automatic opening of the applicable switchyard circult breakers accordance with design.

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As expected, the scram resulted in a decrease in the reactor vessel water level due to the decrease in the void fraction in the water. The decrease, to approximately +4.5" (narrow range level), resulted in the automatic actuation of the Primary Containment Isolation Control System (PCIS) and Reactor Building Isolation Control System (RBIS) in accordance with design. The PCIS actuation included the automatic closing of the Primary Containment System Group 2 isolation valves (sample valves) that were open and the closing of the Group 6 isolation valves (Reactor Water Cleanup System). The RBIS isolation signal resulted in the automatic closing of the Secondary Containment System/Reactor Building ventilation supply and exhaust dampers and automatic start of the Standby Gas Treatment System.

Utility licensed operators proceeded to take the actions to place the unit in a cold shutdown condition. The insertion of all control rods was verified.

The NRC Operations Center was notified in accordance with 10 CFR 50.72 on December 27, 2001 at 1603 hours.

During the cooldown to cold shutdown, at approximately 0330 hours on December 28, 2001, minor notching of reactor vessel water level instrumentation was observed on the "B" reactor water level instrumentation. No notching was observed on the other reactor vessel water level instrumentation. The notching was investigated and evaluated for impact on operability of the related instrumentation. The evaluation concluded the instrumentation was operable.

The Residual Heat Removal (RHR) System was put into service in the shutdown cooling mode at 0437 hours, with one RHR train "B" pump in operation. Cold shutdown conditions were achieved at 0550 hours.

A corrective action program document (PR 01.8151) was written to document the scram. PR 01.8152 was written to document the reactor water level instrumentation notching.

CAUSE

The direct cause of the scram was an automatic trip of the circuit breakers that power the drive motors of both Recirculation System motor-generator sets. The trip was initiated by the ATWS/RPT circuitry. Testing of the ATWS/ARI circuitry after the event verified the ARI circuitry operated properly and an ARI trip did not occur. The ATWS/RPT trip resulted in decreased core flow that resulted in trip signals from the neutron monitoring system flow control trip reference circuits in accordance with design.

The root cause of the scram was an internal failure within the calibrating unit that was not reproducible. Circuit analysis and other investigative efforts identified the most likely failed component within the calibrating unit was an intermittent micro-switch. A failed micro-switch would apply 24V DC from the calibrating unit to a master trip card while rotating the same rotary selector switch between channels. This failure would bypass a system interlock designed to prevent selecting a channel while rotating the calibrating unit "press to cal" knob.

The suspect calibrating unit was functionally tested with satisfactory results before and after removal from the ATWS Division 2 panel. The calibrating unit was manufactured by Rosemount, Incorporated, model number 510 DU.

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CORRECTIVE ACTION

Corrective actions taken included:

The suspect calibrating unit was replaced with a Rosemount model 710 DU calibrating unit that is equivalent to a model 510 DU calibrating unit.

The ATWS Division 2 panel was inspected with satisfactory results.

The ATWS Division 2 trip units were functionally tested with satisfactory results.

Corrective actions planned include:

Revision of applicable surveillance procedures. The focus of this action is to verify that no alarms and/or trip unit status light actuate and the calibrating unit "cal" light does not initiate during the manipulation of the rotary selector switch.

Evaluation of other analog trip system calibrating units.

OTHER ACTION TAKEN

The "B" reactor vessel water level instruments were vented and the related instrument rack was backflushed. Longer term actions are being tracked in the Corrective Action Program.

SAFETY CONSEQUENCES

Although the failure of the calibrating unit micro-switch resulted in an unnecessary plant transient, the event posed no threat to public health and safety.

The scram was the designed response to the high neutron flux trip signal that resulted from the trip of the Recirculation System motor-generator sets/pumps that occurred while at 100 percent power. The trip of the MG sets/pumps was the designed response to (false) trip signals from the ATWS Division 2 circultry for the Recirculation Pump Trip function.

REPORTABILITY

This report was submitted in accordance with 10 CFR 50.73(a)(2)(iv)(A) because the RPS scram signal and consequent PCIS and RBIS isolation signals were not planned.

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SIMILARITY TO PREVIOUS EVENTS

A review was conducted of Pilgrim Station Licensee Event Reports submitted since 1987. The review focused on reports that involved ATWS or ATS and/or applicable procedure. The review identified no similarity.

ENERGY INDUSTRY IDENTIFICATION SYSTEM (EIIS) CODES

The EIIS codes for this report are as follows:

COMPONENTS	CODES
Condensing unit (Reference leg "B")	CDU
Panel (ATWS Division 2)	PL
Pump	P
Switch, hand (knob)	HS
Switch, indicating, pressure (PIS-263-123D)	PIS
Transducer (calibrating unit)	TD

SYSTEMS

Engineered safety features actuation system (RPS, PCIS, RBIS)	JE
Incore monitoring system (neutron monitoring system)	IG
Reactor Building	NG
Reactor recirculation system	AD
Residual heat removal system	BO
Solid state control system/Auxiliary logic control system (ATS)	JG
Standby gas treatment system	